Meaningful Use Workgroup
Draft Transcript
May 10, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Meaningful Use Workgroup call. This is a three-hour call, Federal Advisory Call, so there will be opportunity at the end of the call for the public to make comment. Just a reminder to workgroup members to please identify yourselves when speaking.

Quick roll call: Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Bates? Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families – VP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Neil Calman?

Neil Calman – Institute for Family Health – President & Cofounder
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Art Davidson?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Lansky? Deven McGraw? Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Michael Barr?

Michael Barr – American College of Physicians – Vice President, PA&I
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jim Figge couldn't make it, Paul. Marty Fattig? Judy Murphy's coming late. Joe Francis? Karen Trudel? Josh Seidman?

Josh Seidman – ONC
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anyone off? Okay with that, I'll turn it over to Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good. Thank you very much Judy, and thank you everyone for participating on this call. We just met face-to-face about a week ago, so thanks for your tolerance in terms of us getting the materials out late, trying to do things just in time, and in fact of course, this was just in time before tomorrow's presentation. The three major topics we have for today; one is to finish up category four and Art's been so patient with us in terms of postponing so he'll go first. Then we'll start a timely discussion. We put together just a draft matrix, and that'll actually be coming your way during the call, just to start discussing did we get the attributes right. To make a clarification about the EHR certification program and how it interacts with the objectives because I think that at least seemed to clarify things for me, and hopefully Josh can also keep us straight on how they interact, but I think it actually may make some things more palatable.

Then finally, I realize you didn't have a lot of time to study it but to go over some of the PowerPoint draft that we have for any last minute tweaks. Again, this is still for the HIT Policy Committee to give us some feedback. We still have another round before we're presenting our final recommendations in June. So this doesn't have to be final at this point. Any questions on the agenda then?

Okay, let's start out with Art talking about category four. There should have been a handout sent your way this morning.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right, so thank you Paul. So hopefully everybody has this handout that's labeled Population Public Health MU Measures. It's a PDF that you can download if you haven't got it. There are in stage one, three different criteria that are used in population public health meaningful use measures, and you'll see that today we'll be talking about a fourth one. I don't think there's much change really in the first three. We've done a little bit of cleaning up and clarifying from stage one.

Earlier on, we had the discussion around how in the first item, this first criteria, around immunization registries, that in stage two that would be moved to core. I think this misunderstanding, or for me, I think it's a misunderstanding about what the wording in stage one really is saying when it says perform at least one test and then capacity submit electronic data to immunization registries and follow-up submission if the test is successful. So I've tried to survey several people about this, and I'm not sure what that—if the test is successful, if there's a failure on one side or the other, how do we get to the point where the test is successful? When we move this to core, if the test is still unsuccessful, what do we do?

So that's an item that we tried to deal with in a way that had been dealt with in other areas around moving progressively from 25% to 80%. I know that in the last call or one of the earlier discussions, several of you have said that doesn't make sense. We should just be submitting everything. I think the problem for me is what does if this test is successful mean? Some people have said, well if the state is unsuccessful in receiving it, then the hospital has done what they need, but it doesn't say that. It says if the test is unsuccessful, I don't know if the hospital has been unsuccessful in sending it to a state where it is available and ready to be received.

So I think that was a concern, and I'm going to stop there, and I know that there's discussion the last time, I don't know how we resolve this. Is there better wording here around if the test is successful?

James Daniels – Medical College of Wisconsin – Associate Director

Well, can we get rid of the test … two? If they submit electronic data to immunization registries on at least 25% immunizations given, unless none of the immunization registries reason to which the EP, EH or CAH submit such information at the capacity to receive the information electronically, period.

Art Davidson – Public Health Informatics at Denver Public Health – Director
That would be an option, and I guess we don't even need the percent then as Neil would probably say.

James Daniels – Medical College of Wisconsin – Associate Director
Well, either you're attesting that you're doing at least one or you're measuring a percent, but you can't say 100% because the whole point of having thresholds is because we've realized that there'll be something that we're not thinking of right now.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Okay. I'm in agreement with that. Last time, I think Neil was the one who had the most problem with the way this is progressive with percentages and felt like we should just be reporting everything.

Neil Calman – Institute for Family Health – President & Cofounder
What I said was, if you made a successful test and the recipient can accept the immunizations, why would anybody report 25% of their immunizations.

James Daniels – Medical College of Wisconsin – Associate Director
Well it's just a threshold for deciding meaningful use. That's true of order entry, it's true of—well I guess order entry is saying you might do one area. But immunizations you're not just doing one area. Is it possible you might be doing one area of pediatrics? I don't know.

M
By putting those kinds of thresholds in, I think it's irresponsible because basically we're encouraging people to not do this stuff completely, and I think having incomplete stuff is almost worse than not submitting at all.

James Daniels – Medical College of Wisconsin – Associate Director
Yes. But in other places we said 25, you just have to show you did it 25 times and we assume you're going to do it all. So we could say you have to spend at least 20—elsewhere in stage two, three places I think we have at least 25 records that have been sent.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Actually Neil, aren't there childhood immunization registries that not necessarily applies to adults for Pneumovax, let's say?

Neil Calman – Institute for Family Health – President & Cofounder
Well what you say is once it's been tested successfully that meaningful use means submitting all immunizations that are receivable by the recipient health department.

James Daniels – Medical College of Wisconsin – Associate Director
And that's really what stage one says already too, if the test is successful you have to go into production per state and local regulations.

Neil Calman – Institute for Family Health – President & Cofounder
Right and that's what this should say?

M
Okay, who was just speaking please?

James Daniels – Medical College of Wisconsin – Associate Director

Sorry that was Jim Daniels just making the comment that for stage one, we already say if the test is successful, you have to go into production per state and local regulation, which would be all immunizations.

M
So, Jim is that stated on this sheet? Is that in the rules?

James Daniels – Medical College of Wisconsin – Associate Director
That's CMS's clarification of what you post a successful test.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Can you tell me why you need a test at this point? You could argue we could test everything. Is it because we want health departments that aren't going to accept it still to be able to test their local provider even though they know they can't receive it in the long run? Is that the purpose of tests?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think originally George that was it but you have a good point. It's a matter of—well I'm not sure in 2013 whether everyone in the country can report 25% of their immunizations to some recipients.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, on that one I would agree with that. Again, I think the purpose of the test was to make sure that you've got the infrastructure in place to be able to do that so it was more getting us ready as opposed to going into production. That was kind of a surprise.

James Daniels – Medical College of Wisconsin – Associate Director
Well, I think the way it's actually going to work out is per state and local regulation is going to end up meaning that if you have a successful test, you're put into queue and you go into production as the health department is ready for you.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay so that would actually have a time issue in terms of when you would test that. So if we say it's got to be in production and that if you're in the health department queue then that's a challenge.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Well, not really because that means it's not accepted yet so therefore you're exempt.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Well you can do the test potentially separate from when you go in production.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So you would be I think CMS should count you as successful test, not accepted by health department yet therefore it still meets objective.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, can I hear a reaction to Jim's proposal, which now this means instead of moving in it from menu to core, and the successful passing of this measure still means you must perform a test. If that's successful and the public health agency can receive it, there's no reason why that shouldn't remain on and information flow. Wouldn't that meet the spirit of this requirement?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Well, it still raises Art's question, which is what if you have an unsuccessful test, do you have to fix it? Let's say your EHR is not working, is that ... to get meaningful use?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The test is a combination of testing your functionality but as we explained originally in stage one, it was really to not penalize you for your relevant public health agency not being able to receive it. So maybe

we can change the wording to that, if you're relevant public health agency can receive it, then you must send it electronically, something like that.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I agree. I think we have to separate the population because the test is as you just said, I think applicable to public health agencies that really don't quite have the infrastructure yet. But the point of the test in my opinion was also just starting the conversation and send the signals to the public health agency that you've kind of like got to get ready for this. So just to keep people going on the escalator, it might make sense to actually separate, okay if you are in a state where—you should have tested last year, so if you're in a state where they can't accept or there is no test and then if you're not, you try to perform another test.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, let me pick up on what George said, maybe just this concept of test is a little outdated at this point. Just like in labs, we say, well we're the labs can give it to you, you should be able to receive it in structured format. This is the same analogy that says well the public health agency can receive this, you ought to transmit electronically. That's very much like many of our other criteria.

Christine Bechtel – National Partnership for Women & Families – VP
I agree with that. What I'm trying to also figure out how to do is for those places where they cannot accept that, do you want to keep … in there so you kind of keep having providers ... the public health agencies as a way to start a conversation about when you're going to build the infrastructure? How much progress have you made, as opposed to just leaving it like you don't have to do anything in a state where it's not accepted.

James Daniels – Medical College of Wisconsin – Associate Director
I think Jessica has been pretty clear that test messages have to be sent to the receiving entity that would eventually receive them, so I'm not sure if that would help. I did want to point out one other piece that you guys alluded to and just clarify that as well. As far as the failed messages, for stage one meaningful use, if they send a message and it's completely ill formatted and the state health department says I can't do anything with that, they are off the hook for stage one meaningful use and you would need bring those guys back again somehow to next year.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
What do you mean they're off the hook or they—

James Daniels – Medical College of Wisconsin – Associate Director
That's all they have to do for year one. If they send a message that's so bad the health department can't do anything with it, they're done.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's why I think the word test is a little—we may be beyond that in stage two.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, I agree with your formulation earlier about moving to—just doing it and the denominator would take care of that if it's not available. I do have a separate issue though. It may have been discussed elsewhere. I'll just raise it here and you can talk about it in turn—25% of immunizations given, does that mean only those were administered by the practice or is it vaccines that are also recorded that were provided elsewhere?

Art Davidson – Public Health Informatics at Denver Public Health – Director
This would be referring Michael, to those that were actually administered rather than the history. Certainly, we want to catch up on the history but what we can record in the EHR are the procedures done.

Michael Barr – American College of Physicians – Vice President, PA&I

We can also record historical ones but I think it's going to be a clarification issue for folks because that'll come up in comments.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I agree and we would actually like to get all that information sent there, but I think we're just trying to do the minimum at this point.

Michael Barr – American College of Physicians – Vice President, PA&I
That's fine. I'm just suggesting it should be a clarification.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The other point though is I'm not sure that everyone has the same degree of validation of the historical, and I'm not sure we want to pass people's historical …. I think the administered is the a better—

Art Davidson – Public Health Informatics at Denver Public Health – Director
Well, actually Paul the historical is important in that in stage three where we're trying to use some of the capacity to receive information from the registry, it would help inform what would be appropriate to give the child or the adult based on just the full history that someone might have spread across many records.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We just have to find a way of indicating somehow ...

Art Davidson – Public Health Informatics at Denver Public Health – Director
I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay so where are we on the, I think— Let me see if people are comfortable with removing the test characterization for stage two, thinking that it's almost where appropriate, where the health department can receive this information, you should be communicating this electronically.

Art Davidson – Public Health Informatics at Denver Public Health – Director
So can we just say submit electronic data to immunization registries?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Where they can be—

Art Davidson – Public Health Informatics at Denver Public Health – Director
Unless in accordance with applicable law and practice. Does that sound good, Jim?

James Daniels – Medical College of Wisconsin – Associate Director
Yes. That does. That sounds great, and then I think you'll get at most of the other issues you're concerned with but not put undue burden on some health departments where they actually have laws that don't allow them to accept historical data without going through a very onerous consent process. So I think leaving that per state and local practice in there is great, and then the health departments can enforce what they can do to the maximum level.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So we're calling it submit immunization data in accordance with applicable law and practice, move to core for both EH and EP. Is that what we're saying?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I believe that's what we're saying, George.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
And then, the measure—is it 25%, 25%, 80% or something else or a test—or a test to the fact that you have at least one. A test is kind of like the 25. Remember Neil, that we had talked about what if a large

portion of your patients come from out of state, you can't hook up to that one, but you can hook up to your local one. Those are the kinds of things we were worried about, which is why we picked 25%. Plus the theory that they would do them all anyway, all that were possible.

M
But we've always said that if you can't do it, you can't do it. I mean if the health department's not ready or can't accept it, that's the out. I don't feel the need to insist on this. I just think we want to move people to do it wherever possible and to do it as completely as possible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
How many of these interfaces do you imagine an entity would have to communicate with in a state or local area?

M
... one except California.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Say that again please.

M
Each state generally has one state registry, except California, which has some locals.

Art Davidson – Public Health Informatics at Denver Public Health – Director
But there are individuals practicing in the tri-state area that may have patients from all three states.

W
That's a great catch.

M
And New York City has its own immunization registry.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes. So I think the majority of the states probably have just one but there are many exceptions to that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And how do we want—these are all additional effort, additional costs. What kind of threshold do you want to set up for these folks who see patients from multiple reporting agencies—that are called by multiple reporting agencies? Could we use the at least one kind of test? Not test. Can we use the at least one kind of criteria?

Christine Bechtel – National Partnership for Women & Families – VP
I have a question. Would applicable law and practice—I've heard of in other words … the law say you have to report to both your local and your state if they exist, in other words … the law cover it? Or do we need to cover it?

M
I think the law would probably cover that in most cases, but the one that you guys brought up about having kids who live in three different states, the law probably wouldn't cover that one.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes. I don't think so. If the practitioner is in one state, the state law's from another—

M
Although then would it even apply to them? I don't know.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

That's why we're trying to be a little flexible because we don't really understand all the implications of a policy and what can go wrong, so if we do submit immunization data, test to at least one in accordance with applicable law and practice move to corporate EH and EP. That would be a big step up from before where it was just a test and if you did something stupid, you got off for free. So I think this is stronger than stage one.

W
Yes. I agree and I think even the practice of applicable law and practice may cover some of these circumstances where we're just trying to get things done electronically but it's largely reflective of current practice.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This is an escalator, and we're only on the middle stage so I think George's latest rendition, which is the at least one kind of thing consistent with local practice and state law would cover it. We're moving it from menu to core where essentially most people are—well we're moving it from menu to core.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Does there seem to be in agreement about this?

M
Yes.

M
Good.

Art Davidson – Public Health Informatics at Denver Public Health – Director
So I don't think we'll spend too much time on stage three but I think we have highlighted here in the last column that we're talking in the second bullet, the first bullet is essentially—we can rework the wording on that similar to what we just did. The second bullet though, talks about viewing accumulative immunization records, which is the next phase of really using the immunization registry to drive behavior change so that you can see what has been given and maybe get a recommendation from the registry. So we're signaling to the industry that there's a need to receive something back from the immunization information system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well that's an important signal. It's important functionality and I think the challenge is going to be mostly on the public health agency but it's a good signal to put in there.

M
Okay, I'll put in stage three accumulative immunization record.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, I wouldn't deal with the numbers because I don't think that's where we are yet.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes. That's great.

James Daniels – Medical College of Wisconsin – Associate Director
Do you have anything about viewing the recommendations as well there?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Thank you Jim. We should call that out as well that there'll be this recommendation likely from the aggregated record that exists at the immunization registry.

James Daniels – Medical College of Wisconsin – Associate Director
That would certainly end the comments but not only the whole history but the recommendation.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right. Good. So we'll move to the second item, which is about the capability to submit electronic data on reportable as required by state or local lab results. This was menu and this is for hospitals. We have now moved that to core. I think what we tried to do in this stage two is to talk about that there's a completeness to the reporting, that's the percent that we have here, 25% of reportable lab results. Now again, I think I agree with Neil's comments that this should be 100% but it was stated as similar to the first item, the immunizations, at least one test. So we just wanted to move to, it's not testing anymore it's about sending the data. So if we want to remove the percentage here, I'm comfortable with that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And then replace it with a put in place one—

Art Davidson – Public Health Informatics at Denver Public Health – Director
It's basically at this point now it would just be submit the reportable lab results.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Will these be the same agencies or will there be different or more?

Art Davidson – Public Health Informatics at Denver Public Health – Director
So they could be the same, and they could be different. In some places, the electronic lab report—first of all it'll go to different parts of the same agency but the immunization registries may be operated separately from the state health departments in some places as Jim pointed out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And it certainly could be to different systems, which means it's a different interface.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So could we use the at least one phrase again?

M
Is that at least one type of reporting or at least one public health department?

Art Davidson – Public Health Informatics at Denver Public Health – Director
No

M
I'm just trying to ask what Paul's asking.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think it's the interface. It's really the … interface. It's working out the logistics and making sure you get all the data needed to at least one place.

M
Yes, I would agree to that.

M
What's that Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There are some local that accept it in addition to the state. So yes, I think instead of getting caught up in how many just because of where you're located, we just want to start data moving, and it's a big effort to try to get that interface going. So it's really reporting to at least one organization that receives reportable lab results. Is that list in parentheses—is that a standard list?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Well we should have not tried to put—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
… standard, right?

Art Davidson – Public Health Informatics at Denver Public Health – Director
There is a standard. There is a reportable electronic lab reporting standard. It's HL-7 message, and I put that in there for at one point, I think we can remove that and that can be the work of the Standards Committee.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Art Davidson – Public Health Informatics at Denver Public Health – Director
So that all comes down and I don't think there'll be any change really for stage three. So we're basically on that same path and if we can get hospitals to be reporting, that would be a major achievement.

James Daniels – Medical College of Wisconsin – Associate Director
It really would. Did you want to add the per state and local regulations like the immunizations too or ... for that?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right. That should be in there too. So I guess—sorry Jim, go ahead.

James Daniels – Medical College of Wisconsin – Associate Director
No, it just does seem to help with things that we don't ….

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right. I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, any further comments on this one.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This is clarification and this is just only EH then in this scenario?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes. That's correct.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Because I thought we had EP but that discussion I—

Art Davidson – Public Health Informatics at Denver Public Health – Director
They removed that. After previous discussions, we removed that. There is a fourth item we'll be talking about in a little while.

So in the next area, if there are no other items to discuss regarding electronic laboratory reporting, we go to syndromic surveillance. Here we had decided that this would be moving to core for hospitals. That's where most of the syndromic surveillance now is happening in the country. There are some places that have ambulatory care reporting for syndromic surveillance but that's a little bit less common. This is a discussion we haven't finished yet about whether there are menu items or not in stage two, but when we had the idea that they would not be, it seemed like the EPs would not be asked to have syndromic surveillance reporting. But since David Bates had suggested maybe we should reconsider that in his discussion about care coordination, I put this back in there for EPs as a menu item.

So I think it's pretty straight forward for the hospitals. I think the question is shall the eligible providers have this as a menu item? We can again remove perform successful test from this wording and follow the same pattern we used for the two previous items about submit syndromic surveillance.

James Daniels – Medical College of Wisconsin – Associate Director
So, the ISDS is just now working on the standards for ambulatory care, so I just think we should be somewhat mindful of when we think those might be done.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I would almost say that we wouldn't put in for EP at this point unless we start having a whole bunch of menus. So far, we only have one. So I guess my tendency would be not to introduce this yet based on what Jim just said.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Okay. I hear that and indeed ISDS is working on this, and it may not be ready, but I think they're working pretty seriously on it. So it's possible that it will.

Back to your point, Paul, the menu item that we have yet to discuss is a fourth one, and I don't think there's any way we're going to make that core. So this next one is one that I feel the public health community is pretty excited about trying to get included in stage two so we can leave out EP syndromic surveillance at this point. It probably will come back. I know there are communities where this is being reported currently, and I think those communities would like to see that highlighted at some point so they can continue to have that feed to monitor the health of their population. That may be in stage three. If we all feel—Jim, do you have a strong feeling about this?

James Daniels – Medical College of Wisconsin – Associate Director
Well, you made a really good point about the entities that are accepting it already. You don't want to undermine that activity.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right.

Michael Barr – American College of Physicians – Vice President, PA&I
If people are doing it already, they should get credit for it under a menu option.

James Daniels – Medical College of Wisconsin – Associate Director
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. Because upgrading to a new standard and all putting that in place is a challenge.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Now are you referring to the case report or are you referring to the syndromic surveillance?

Michael Barr – American College of Physicians – Vice President, PA&I
Syndromic. So for instance, I believe in New York City, they have a pretty significant program going there.

James Daniels – Medical College of Wisconsin – Associate Director
Yes. And the city of Boston as well.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And Pennsylvania has one.

M

And my institution as well from the outpatient area.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We could have a list of things that we put on the table for CMS to consider, and they have the ultimate decision anyway but instead of baking it in as a menu—that's yet another option.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Do we really want to add for EP both reportable conditions and syndromic surveillance. I guess if one or both are menu and that's what makes it easier, I see.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Just thought I'd confirm EH submits syndromic surveillance data attesting to one in accordance with applicable law and practice moved to core, ISDS is working on syndromic surveillance guidelines. Is that right for the first half?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Well for ambulatory care, they're working on those guidelines. For the hospitals and EDs, I believe it's completed.

M
… published.

M
So that's the Standards Committee so I just delete that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I didn't think we got to reportable conditions yet.

M
No.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Alright so why don't we go to the next one as we ponder whether to put this in menu or a consideration list and see if that helps us if we're moving towards a set of things on the menu that may push us one direction.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Okay so I'll move to the next one then, Paul, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And then we'll come back.

Art Davidson – Public Health Informatics at Denver Public Health – Director
So this is the one that came up after our discussion last time where we had suggested that maybe we could do something analogous for eligible providers around electronic laboratory reporting. There was a lot of pushback about doctors reporting even though that is their responsibility and virtually every state and jurisdiction, but most docs don't report. They depend on the labs to report. But there are some conditions that don't require a lab test so the lab can't report them.

So we went back and worked on this and came up with this menu item that providers would have a mandated public health case report. Paul, the last time asked if there's any standard out there so we have done work to try and find it and IHE has a cancer reporting standard that uses a CDA and that what we were suggesting here and my public health colleagues was that we start in stage two with the

standard that exists. So you have a menu option to report a case of cancer to a cancer registry, and that in stage two that could be this menu option and the method is the IHE CDA implementation guide, which is based on HITSP C32.

So we would move that to stage two and then in stage three, given another year or two, we believe that CDC and CSTE would have completed the core requirements for public health case reporting for many other diseases. We don't have that ready right now. CSTE is working on that (the counsel state and territory epidemiologists) with the CDC. So in stage two we're asking that EPs have a menu option for reporting case reports and that that in this instance right now would be just around cancer reporting because that's the only standard available, but again it's the escalator. It's figuring out how to get EHRs to begin to see that they have a role in case reporting for many things beyond those that are only identified by a laboratory test.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well it's interesting. I think what we're faced with it that you're trying to open up these doors, and what we're faced with is an example, an instance where the standards and implementation guide exists but it is in a relatively narrow domain i.e. cancer. So we've used menu in a couple ways. One is the option may not be available to everybody, i.e. you don't have any recipients like in public health agencies, and the other is the subjective may not be relevant to your specialty. So, I think that concept is a good concept.

Now if we take the objective before for EPs plus this one, we would only have two menus and you could see how neither of these might apply to a given, let's say, EP. Which would leave us in—don't know how to specify pick one of these menu items when you could see how both of these could not be applicable or available.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right. I hear you, but we are trying to open the door as you say.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Other thoughts and then maybe is there room and would this be useful to CMS, ONC to have a list of hey these are some door openers that would be that we're working towards in stage three for your consideration kind of thing.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Art, is there some way to have them use text instead of a standard so that we'd—like is cancer the most important thing that public health agencies need to hear about today?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Well, I think the feeling is in the public health community that it'll be so vague and so burdensome if we don't have a standard that we shouldn't go there. It would be burdensome on both sides if we don't have a message standard.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I see that concern but then I don't know, it sounds like a lot of work, I know you're trying to open up the doors but to have people sending cancer information to the public health department falls short of what they're trying— It'll just be seen as okay, this is a meaningful use thing not something useful to me. They're really caring about the other reportable conditions.

Art Davidson – Public Health Informatics at Denver Public Health – Director
On the contrary, I think the cancer registries are ready. They are ready to receive these reports. This is the work of the public health data standards ... with IHE was to push this and I believe in a newborn screening standard as well through, and we just selected this one as an example for stage two. The National Association of Cancer Registries is definitely on board around this. This is not a burden to the Health Department Cancer Registry. They have been working towards this goal for a while.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

So submit the portable cancer conditions, attest to at least one in accordance with applicable law and practice and then to the HITSC possible use of cancer report, IHE?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Integrating Health Care Enterprise.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So it is IHE cancer reporting standards.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So … are implementation guides not standards, right?

Art Davidson – Public Health Informatics at Denver Public Health – Director
As I understand, there's a CDA standard for that that I believe is consistent with the HITSP C32 document.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So they didn't define s standard, but they picked s standard as part of their implementation guide.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The CDA is the standard and then they use IHE to define the implementation guide around that standard for the particular use case, which in this case would be cancer reporting. So just like Paul said, it's a refinement of the use of the standard CDAs an architecture kind of concept.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So we could put this as a possible—label it possible menu item. The only way this would go in because you can't have syndromic surveillance and cancer reporting be the only two menu items to pick one because they're very similar to the EP. But if you if, for example CMS takes some of the things moved to core and says we need to leave these as menu a little longer, if it makes that decision, that's where the possibility of having these menu items opens up I believe.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's what I was trying to do with this "list," this list of things for CMS and ONC to consider. Basically using your logic, we can't put just two menu items that may not be applicable to a lot of people. So if we put this on this list, that's a signal and the federal government has far more levers than meaningful use to apply. So this can just be introduced into some of the things to consider. Who knows, it could work its way into something that's the CDC does and it was completely separate type of program because a lot of these things have to do with who's receiving it and what do they do with it.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right, although most of this—according to the constitution, the states really have the right and the responsibility for the position of health or monitoring that. So the CDC, I don't know if they have the same power as you working locally ...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any other comments about these concepts and then we'll take a sense of the group as far as putting it on this list as considerations versus trying to find a menu?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, I think this one although I'm not sure it was probably net new functions, so that's one consideration. The second one is that I did verify, you mentioned earlier on for instance doing alerts for reportable conditions, whereas reportable conditions today vary, there's not a standard, clearly many systems are capable of being configured to do alerts in the model today. So again, that would be probably be some net new functions too, but the capability is there. It's just that would have to configured in those systems.

James Daniels – Medical College of Wisconsin – Associate Director

I'm just going to throw out a comment that I heard several people mention at a meeting I was at the other day with the National Association of City and County Health Offices. Where they were asking about having reports from physicians that actually add to the laboratory information, not necessarily replace the lab—not re-reporting lab information but adding to it. The examples they brought up were for things like sexually transmitted diseases, to be able to pick up treatment status and pregnancy status. Their reason that was important to them was EMRs greatly increases the number of reports that they have to deal with and without having that additional clinical information, there would be an physician EMR, it's hard for them to have actually follow-up on every case that they get. I'm wondering if that concept might be something to think about in public health case reporting as well.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Those are excellent points. I think the reason why we backed away from that—and I'm totally in agreement with those comments—is that there's no standards to determine how to send the information about pregnancy or treatment status. The essence of this problem is that we don't have CSTE nor CDC have not yet provided with us the proper message format and got that vetted to the point where we can do that. I'd love to do what you're saying, but I think where we're looking for a stepping stone in stage two with this cancer reporting, and I think Paul points out all the flaws with that, and it doesn't' apply to everybody. It's a small group but we thought this would be one way to begin signaling the message we are expecting public health case reporting to occur by stage three and that we're trying to make an effort around that in stage two. But I would hope that by stage three, we address the issues of pregnancy and treatment in these standards.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I'm wondering if I could summarize where I think we are. Would you be open to putting these two items on our consideration list and if we do end up with a robust menu selection, then we could move it into that. Right now, I think we're leaving a lot of people out if we only have these two menu options.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I'm willing to do that, but I do think that—we're hoping that stage three as listed here on the fourth line or the last line of this table, that this moves to core. That we've hopefully got everything lined up so that it is now a standard functionality, maybe new as Charlene points out, but it's standard functionality that there is public health case reporting from EHRs.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay so in stage two, is this the public health submission button or not?

Art Davidson – Public Health Informatics at Denver Public Health – Director
No. I believe that as this point we are shying away from this idea of a button.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can you explain that Art?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes. Because this whole process of a button got people concerned about why do I need to be reviewing things if there's a set of criteria that you can set into an algorithm that defines what is sent? Doctors currently do not follow that at all. Rarely do doctors—or providers again—providers send reportable case reports to local and state health departments. They depend on the labs. So by having the button there, we got the message to some providers that now I need to go through all these reports and decide whether they should be sent or not.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So that sounds reasonable and we'll determine over time if the button' the right way to do it, but we don't need to specify it here. Then we also had stage three patient innovated data, is that still in?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes. So I think we can still signal that for stage three but we really haven't gotten there.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Very good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any final comments on category four? Thank you very much, Art, for preparing that. It's very nice and concise.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Thank you Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Alright. Let's move on to the timing discussion and let's just see where we end up. Now you should have received by e-mail while we were talking at the beginning a draft of a timing matrix and also an excerpt from the certification criteria that I think is very helpful for our discussion. Do people have access to their computer so they pull that up?

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I'm still in transit. I will but probably not for about 10, 15 minutes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay well I'll verbalize it. So the important part—and Josh, you're on, right?

Josh Seidman – ONC
I am.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So please check my work here. So the important part is if you look at the second page, where it says table one and it talks about the relationship between the certification criteria for EHRs and the EHR modules and the meaningful use stage. What I highlighted in yellow was that 2013, and this is a lot with what George said in our face-to-face. So if you see there's only one group—the early adopters who enter in in 2011 for stage one—that is directly affected by the timing constraints of stage two being in 2013. In other words, they are required to meet the stage two objectives and if your hospital start reporting by October of 2012. That's where you get this three-month time constraint. What you see below is that the EHRs that are currently certified in 2011 have that certification effective—and the term that Farzad used was very helpful—let's say phase one, which is the current phase we're in, they're certification goes from 2011 to 2012. Am I right Josh?

Josh Seidman – ONC
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, then the next phase of EHR certification by the current timeline would occur in January of 2013 to be good for 2013 and 2014. That implication is where we're having this, it must be developed and tested and deployed kind of a problem. So along the lines that George was saying in our face-to-face, if we simply moved stage two one year, which would make it start in 2014 for everybody—and again this only impacts really the 2011 entrants, then we will not move it per se for the substantial majority of folks who are entering into the program. Yet we are buying an extra year for development and implementation. So Josh let me ask you to check that statement.

Josh Seidman – ONC
Yes. I think that's basically right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that almost seems like a very reasonable answer, and yet we would have to decide what happens. When the final rule comes out anticipated in middle of 2012, the certification rule would come out so that vendors can begin work on their development immediately in preparation for people to need it by January of 2014, at the earliest.

M
But what happened to the right hand part of the chart that got cut off?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well there's no rule yet. They said it's a TBD, basically, for 2015. They did not rule on that in the final rule.

M
Right, the NPRM had a suggested and then the final rule said TBD.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

M
So it could potentially go beyond 2015.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Oh yes. Well first of all, the secretary's authorized to continue having a stage four if she wants to and it still would affect people's penalty phase.

Josh Seidman – ONC
Right, just not the incentives.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. Just not the incentives. The incentives, if you are not there by 2014 in Medicare, it's over.

Josh Seidman – ONC
Right and just to clarify this is all for Medicare. Medicaid is—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Medicaid is very different.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, what you're then suggesting is where you've highlighted stage two, the simple, I would just read stage one and so the folks who ended in 2011 could go through stage one all the way through 2013, get really good at it and then get ready for stage two in 2014 along with those who started in 2012.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's correct.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So Paul, I think that offering that as one of the options to CMS is the only path we can take right now. Because we don't know how adoption has gone until a year from now or whatever nine months from now so our list of options, this just makes it clear that option three is a viable option and not something that you need discard off hand. On the other hand, if it's going really well, CMS may decide to go with option one or two or four.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. It just seems like the perceived penalty or consequences of delaying that is just far less, it affects far fewer people and it really—with this in mind, it really doesn't disturb the momentum that much.

Josh Seidman – ONC
Let me throw out one other piece of it. The other thing is basically that—well if you start in 2011 or 2012 you would have up to five payment years. So the difference there is that people who started in 2011 would have three of their payment years, which is $38,000 out of the $44,000 for doing the same stage one. Whereas, the people that start in 2012 would still have three payment years beyond 2013.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We talked about in our face-to-face, that's the side effect. It's not necessarily a bad one because the whole program, this whole decreasing incentive was to move people as early as possible. Like we've said pretty repeatedly, there's no reason once you have EHR in that you say well I'm not going to try to get any more value out of this. I think people are just going to start moving on that escalator. So it seems like it's still consistent with the spirit of the way the incentive program was designed.

M
Still if they didn't meet 2013 criteria, they run the reason in the out years of getting the penalty, right? Even if they weren't … qualified, so people are going to continue down the path to avoid the penalty at the end.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

M
So first of all—

M
One question, it would not delay their payments to stage what the people that met stage one in 2011?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Say that again.

M
Would it delay any of their payments? It sounds like it would not, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No.

M
That's good because we don't want people to be penalized for being—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, there's a bit of incentive. As I say, you can call it incentive or you can call it really irrelevant, that the folks who start in 2011 will continue to get their incentive payment in 2013, even though they're only required to meet stage one criteria. But as we said, there's no reason why you wouldn't want to continue advancing the functionality and get the value out of your EHR. It's just that the floor hasn't moved.

Christine Bechtel – National Partnership for Women & Families – VP
But Paul—and I'm sorry because my phone is cutting in and out, but I just have a couple questions. One is what we are asking for in stage two does require a lot more work flow change. So I'm not completely sure that people will decide—if you look at what I think we're seeing in the field, based on who's choosing what menu items and what core items or ... who's choosing what menu items, it tends to be the easier stuff. So if that trend continues, then they would get like basically an extra ... incentive payment but I don't know that I agree that they still have a motivation to take these changes that are change right so it's not totally easy.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well the comment to that, Christine, is that everyone else besides the 2011 entrants only have to do stage one anyway in 2013. So if that's the path and there certainly has been in the grapevine, people are saying well let's just do the 2012, start in 2012 even though we're ready in 2011 because that gives us more time. That's almost counterproductive to what we want. The side effect of this modification on this table actually rewards the folks for starting earlier. As I say, some of the thing that we're requiring in stage two like secure messaging with ... etc. folks who are starting now already are doing some things like that. People who want to do this and are motivated to start early are already pushing their EHRs even beyond what the vendors deliver.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
So I agree that a number of stage one entrants are probably the more advanced ... which to me it seems like we should be asking them to do more. So what's the difference between—why would we delay it a year, which does not reflect the principle that we've agreed to the escalator as well instead of having a 90-day reporting period? So that they still are spending the first nine months of the year making the workflow changes, doing the patient engagement and education about what to expect later this year blah, blah, blah, the vendors are 90-day reporting period rather than delaying the stage?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Because they don't have the product. So remember we have two things that have to occur for all the new functionality. One it has to be developed in the product, and then two, it has to be implemented.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. So what I think we need to understand and I don't have the chart in front of me, is there are the certification, it cannot just be treated as a blanket problem. It's a very specific problem. So there's a problem where new functionalities actually need to be created by the vendors and then certified. That takes the most amount of time. Then there are, at the other end of the spectrum, there are functions that are already part of the certified technology and we're asking them to be used more or in a slightly different way but that shouldn't take any time. Then, somewhere in the middle are things like secure messaging where most of the systems can do it in a day but they're not certified against it and that's a different timeline issue. So I guess to feel comfortable, I would want to understand the number of function that fall into each of those three categories and then step back and look at okay, do we need to delay the entire stage or do we need to delay only certain functionalities?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well this is where I think a number of our attributes—and I think we may want to be moving up there pretty soon—start weighing in. So the operational complexity of dividing … we already have one stage. Then we would have, if we divided stage two up into two components, we'd actually have three stages operating at the same time. It just gets complex when we don't need to be. I think part of the argument here is for the upgrade it takes a large system like ours a year to plan for and do a safe upgrade where you've got new functionality. It's everything from getting the product, testing it, building it, implementing it and training on it. It takes a long time. So we want people to do this in a safe way.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, I would agree with what you just said even in the small practices, I think what this would allow speaking for the delay is to get this anchored in the workflow and the culture of the practices. They would have a very hard target for stage two that would be developed and would give a little bit more comfort than some of the reach goals that we set forth or that are being proposed in the current grid for those practices. We could help train them and get them up to speed when the products are able and ready to do this in a safe way. Then the transition hopefully would be smoother than just as it is currently being proposed with stage two in 2013. Because I agree folks are going to delay, take the longest time possible in stage one if they can. Even with Christine's suggestion of 90 days, we're really just talking about a three months difference then between that and what we're proposing, and I think that is not consequential and would give us the best opportunity in making sure folks do this in a safe and productive way.

Christine Bechtel – National Partnership for Women & Families – VP

So, Paul, I guess I need to come back to this big picture here. While I think we should be doing is providing options and analyzing them and I think these are—we've talked about lots of options, but I think we need to write out what the implications, are benefits and drawbacks of each option. I don't feel comfortable giving a recommendation of a single approach when our job is policy, this is very much operational. I think it'd be good for us to look at the policy implications of multiple options and really ... them out. But I just think it's more productive and helpful for ONC and CMS to look at multiple options and do good analysis of pros and cons rather than really focusing in on trying to vote on one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that's exactly where I'm headed next, which is let's now go to page one and some of the options that we had discussed. As I said, I think option three, as George points out, is looking different than what we had perceived at the time. So consequently, this draft would be a little different.

M
I like option three.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Hey Christine, I think one of the parallel tracks that we have going on here, which is a concern, is still we have the qualitive reporting that is under a different framework. So again, we need to consider that, but there's no indication that that train is going to stop in the meantime too. So again, I think we'll see some updates there. I don't think the train will necessarily stop.

Christine Bechtel – National Partnership for Women & Families – VP
Are you talking about—I'm sorry Charlene—the quality measures reporting?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The quality measures reporting because I think the message at least I'm taking away is what CMS dictates there is on a separate path from what they're dictating in the overall meaningful use program, if that's correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So let's move to the matrix because that's what we're talking about and let's just start formalizing some of this. So the first line talks about the health reform agenda, and we need EHRs, functional EHRs that are doing a lot of things we've been talking about in order to carry out a reform or a health delivery systems. So let's try to come up with some qualitative assessments in terms of how these various options would impact that, and we have seven or eight of these. I'll just go through them. Let me just list those right now and then we'll go back and see if we can work partly through these various options and how they impact the goals.

The one was use of this infrastructure as part of health system reform. The second, actually it was maintaining the meaningful use momentum up the escalator. The third one is the vendor development timeline that we—particularly for ... functionality, which improves quality measure recording. The fourth one is the provider implementation timeline, how do the various options affect that. The fifth was the need for providers to perform annual upgrades because that's a big .... We also wanted to point out that ICD-10 because it's such a major thing happening at a point in time in 2013 is something we need to consider. The next one is one Jim raised, which is just the operational complexity for CMS and the state for each and every time we have a different program to assess provider qualification forms. Finally, both the quality measurement and reporting and as Charlene mentioned every time that's grabbed, there is an implication to both the EHR and the way that the providers us it to report on it.

So those are things we came up with and let me review the timing option that we have now. One is maintain everything the same, the same timeline from a when does stage two come into play and the one year recording period. The second option and this is … exclusive is to shorten the reporting period to 90 days as it was in stage one. I'll just remind people that has an implication on the quality measures because we've obviously got one quarter of the reporting period then. Stage three—and that's where I think this sort of new understanding of the certification program impacted that is delaying the transition

from stage one to stage two really affecting only that yellow highlighted cell by one year. That would not change when the final rule for certification comes out because that would give vendors and providers that head start on moving to that next stage. Option four that we had considered was to split essentially stage two into well intensification of the stage one kinds of things and the new functionality. That might have been overly complex, and I'll just throw that out as one possibility that we may not want to consider anymore. That may be really complex considering option three, which we though was going to be much more of a shift in the program actually only affects a relatively small group.

So let me just open that up to folks. Do you think we still need to consider option four, the splitting stage two into two pieces or do the first three options suffice?

Christine Bechtel – National Partnership for Women & Families – VP
Paul, can you just explain more fully your last comment about stage three, I guess you said?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Stage three is basically shifting the start of stage two objectives, the criteria for receiving the incentive by one year, and although I think we all perceived including myself that that would have shifted the entire program one year when by this table it actually only shifts one group, the 2011 entrants. So nobody else actually had to change to stage two in 2013 except for that group and that's pretty significant understanding.

Neil Calman – Institute for Family Health – President & Cofounder
Paul, two comments; one is, this is really well done. I think this is really helpful to look at it this way, and I guess what I would say is I'm leaning in favor of stage three. I think we should make ... recommendations of option three. I think we should make this in the form of recommendations the way Christine said, but I think option three does another thing that we haven't talked about yet. I think every time we come out with a set of our recommendations, there's enormous pushback. I think by calling out the fact that there's a small group affected and by giving people more time to develop this, I think it's actually going to help us move the escalator faster. Because I think there'll be less negative reaction to some of the advances we're proposing if there's a little bit more time for people to engage them. I think if we put out a lot of stuff now that people feel like it's relatively impossible, there'll be enormous pushback and the escalator will actually slow down. So I think that there's an advantage in moving this because I think we'll get a lot more of what we're trying to accomplish past the approval stage.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I totally agree with you Neil. I think that this is actually a very positive step. We are not trying to get people to fall off this escalator. I totally agree with you.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, let me agree with your agreement with Neil. I will say that even to the point where the nice table that was developed to present the options, I think is overly negative on the first line, the establishment infrastructure for option three and likewise on the momentum for the escalator. I actually think that this delay will actually strengthen the infrastructure and anchor it in the practices so that they're more ready for stage two. That would get data about the challenges and problems the practices are faced moving through stage one gives it a little bit more time to do the analysis, and I think that will serve as well when we want to get folks moving more quickly up the escalator. So maybe the slope of the escalator's a little slow to start with and maybe that'd be frustrating for folks who want to move it quicker, but I think that it will escalate much quicker after that point because of this delay.

Christine Bechtel – National Partnership for Women & Families – VP
I understand people's support for this option and I see the value and utility. I think what also occurs to me at the same time is the idea that as we went through the stage two criteria, I think there were some areas where we pulled back from the direction that we really wanted to take because of the timeline. So my question is if folks are feeling like option three here, if it's an option would we be willing to actually—there ought to be a tradeoff. So if you get more time, what you deliver in the end actually is more meaningful,

so would we go back and maybe revise some of the criteria that we have already discussed in light of the ..., we'll have an extra year to plan for them and implement them and do them well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well I think we can leave ourselves open for that possibility. Let me try to start moving on to this matrix because I think if we can get some kind of consensus—and I'm sensing we do have some sentiment building—we can actually introduce the concept tomorrow and that would allow us really to do what Christine's saying. As we go back after tomorrow's feedback, we will start adjusting our final recommendations for stage two. It will be much better to have the package including this timing sense as we finalize the recommendations. So I think in order to make progress, may I suggest that we remove option four as we discussed this matrix, obviously for the sake of time, because it adds complexity work. It's not needed, which is new understanding of option three.

Christine Bechtel – National Partnership for Women & Families – VP
I support that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Others?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I support that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think others just like speaking for .... Okay now lets' go through these things. So the first attribute is the use of HITECH to support health reform and sort of ignore these drafts because option three really was developed under the old perception, which is it's … shifting the whole program back. So option one was maintaining the current timeline right now. Let me explain this going from two plus to two negatives. Two plus is it strongly supports this attribute; two minuses is it's significant negative impact on the attributes and zero obviously is no impact.

Let's go down by options. Option one is maintain everything as it stands, current timeline and one year reporting period. Does that help the health reform agenda?

Christine Bechtel – National Partnership for Women & Families – VP
Paul it actually does. I think we shared with ONC and I think a number … the fact that most of these reform initiatives are moving forward much faster than meaningful use ... in play before stage two really even begins. So as I'm listening to you, I almost wonder if for the first group of entrants to position them better for health reform, there are probably three or four things that they need to be able to do. I'm thinking that we ought to look at do we revise stage one for that group so that they're still within the boundaries of what is technically possible with certified product and still add more in stage two as we've been talking about. But I think that's probably the best option, number one the best option for health reform initiative, unfortunately.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay and are there any disagreements—so you're supporting like a two plus to that.

Christine Bechtel – National Partnership for Women & Families – VP
A what?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
A two plus in that cell.

Christine Bechtel – National Partnership for Women & Families – VP
Well, first of all again, I'm not like outside my building because if I go into the parking garage I will lose you guys—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All I'm saying, Christine, two plus says it say strongly supports attribute, and that's what your comments say so I'm just putting the notation. Any disagreement with that? Okay so the next attribute under option one, I'm going option by option, when we're maintaining everything the same it maintains the meaningful us momentum up the escalator.

Christine Bechtel – National Partnership for Women & Families – VP
Again, I think that I think yes it does.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And other people comments or other options?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, I actually think keeping the current timeline does not because people will wait. They will not attest this year. They'll wait until 2012 to 2013 because of the risk of—because you won't get your money for year three.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, can we rename it slightly because I think what's happening is people are—the question is are we talking about what it is on paper if it works? Like if we get rapid adoption in 2011 and everything goes well then this would be maintaining the escalator, whereas if it goes slowly then this might actually hurt us, which is a secondary affect. So maybe I'd call it maintaining MU pace or something like that, that just means timing the thing is just as fast, but then you have to factor in line four. Line four provider implementation timeline, the whole purpose of that was to say this may not be feasible and if it's not feasible the whole program ... fail. It's already accounting for that in another row.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Just call it pace or something that or whatever maybe leave this word, whatever you think but this one's about raw timing and then when we make a judgment across all the rows, then we say, I think this could actually hurt us rather than help us or whatever we want to say.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me switch the strategy in terms of how to discuss this based on George's comment. I think it's going to be easier for us to … rank things option one, two and three for each of these things rather than try to go down. Does that make sense?

M
Yes. I'd just like to suggest that the comment I made is actually another line in terms of the evaluation, which is the probability that the recommendations and the pace of movement are going to be approved in the final rule. I think that needs to be included as a factor. I think the more time we give, the greater the opportunity, the greater the chance that our recommendations will be approved in the final rule. I think that's got to be an evaluation piece because what I'm afraid of is—I'd love to move this quickly but I'm afraid that the pushback will actually end up with a final rule that doesn't have a lot of what we want in it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. I've added that as another line. So support for health reform, option one, two or three—sort of speak to the ordinal ranking there. They don't have to be exclusive to exist. You can have two things that are equally supportive, whatever. So we sort of agreed on option one is very supportive of health reform. Option two is the 90 day reporting period. Is that supportive or not or neutral?

W
….

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Having the HIT infrastructure supporting health reform, option one which is maintaining everything the same would support that. Option two, which is reducing it to the 90 day reporting period, seems like that would not affect things one way or another. I'll just start with a straw man.

Christine Bechtel – National Partnership for Women & Families – VP
Well I think it's still get … going on—like it still gets them going on pace that they know they're going to have to report at the end of the year and so it still gets them to begin to make the changes they need to make.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, I think compared to the original timeline, I would agree with you but again, thinking a little bit broader, and basically, building on Neil's earlier comment, I don't think it's as negative as projected as you go across that row. Maybe if it's compared to the original timeline, but I actually think there's some positives that the infrastructure gets anchored better and is more effective in the long run. I understand this is a simple scale but I just want to weigh in that I think as you go across and it goes from two plus to zero to minus, minus to minus, minus, I don't think that's a fair representation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So what do you want to propose for option two, that's where I'm at right now?

Michael Barr – American College of Physicians – Vice President, PA&I
I think well two and three should get one plus.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay so one plus .

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I'm going to step away as ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay any difference of opinion on option two being a one plus meaning supports health reform.

Christine Bechtel – National Partnership for Women & Families – VP
So the scale, Paul, is two plus and one plus, what's after that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm sorry. I didn't catch your question.

Christine Bechtel – National Partnership for Women & Families – VP
I'm just trying to understand the scale. Two plus?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay one plus is this option supports in this case, it's the infrastructure of health reform. Two plus is strongly support.

Christine Bechtel – National Partnership for Women & Families – VP
Okay but what's after that? So there's zero.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay zero, it doesn't have any—has relatively no impact on that attribute one minus is this option negatively impacts the attribute and two minus is it significantly negatively impacts the attribute.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, it might help to move that page down on the document so we can all see those scoring systems at the bottom.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Oh, I'm not even looking at the Web so if whoever can—yes, I didn't know there was a WebEx. So is that done.

Michael Barr – American College of Physicians – Vice President, PA&I
No. Judy, do you know if that can be done?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. Katelyn, can you just move us down the page there please?

Christine Bechtel – National Partnership for Women & Families – VP
So Michael said shorter reporting period is ... for health reform?

M
....

Christine Bechtel – National Partnership for Women & Families – VP
Then I agree with that.

M
... page one. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so let me move to option three and let me just say, the two negatives that were in the draft are based on the old perception, and I probably would ... that this is actually a two plus for reasons that people said including Neil's point.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, I said one plus but I'll go with you two plus.

Christine Bechtel – National Partnership for Women & Families – VP
Delay one year is two plusses for this group? Is that what you're saying?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Based on the argument, it really only affects that one cell.

M
It only affects people who are advanced users anyway.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And everybody else enjoys the benefit of having a state for implementation. Vendors get to develop the functionality; providers get to have time to implement it by—

Christine Bechtel – National Partnership for Women & Families – VP
I think if we're straight considering, what I'm hearing is completing the development timeline and the implementation timeline. If it's just the health reform … we're considering, and we know that most of the health reform initiatives begin in 2011 and 2012 and they're fully operational and we delay by one year, I don't see how that's anything in the plus. I would say it's a minus. I hear what you're saying in terms of it's a big plus for ... development timeline and implementation timeline and it makes the safer or whatever. But I think for health reform, I don't agree.

M
Yes. This is .... Even though I love option three, I have to agree that on this one issue, which is the preparation for health reform, it does slow that down and there's a bunch of stuff like in the ACL regs and

other stuff that are calling this stuff out as a lot of these functionalities. So I would say probably a zero in balance or minus one for this one criteria.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so I hear a zero one. Christine you are a?

Christine Bechtel – National Partnership for Women & Families – VP
I'm a minus.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And then others?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I would be a zero because I see that there's somebody work on the measures that continue and I think that's going to be important for health reform.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay good point. Others?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I'll go with zero, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm hearing a feeling of zero. Okay let me just put that as a placeholder. The next attribute is maintain the MU pace—that's the better word I think that George added. So option one two or three in comparison, maintaining the pace. Option one is everything the same. Option two is 90 day reporting period and option three is delaying that one cell.

Christine Bechtel – National Partnership for Women & Families – VP
Well again, if we're only considering the pace issue, it's keeping with the same … plus, plus, your reporting period has to be a plus I would say as a one year delay has to be a minus.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Comments from that?

Michael Barr – American College of Physicians – Vice President, PA&I
I think, Paul, going back to your comment that it only affects a small number of early entrants, I vote for option three being listed as a zero.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Others?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think you'll get—this is based on if you give the signal, I would think you would get more starting this year and getting that infrastructure in place. So I mean I'll stay with zero but I think you might get a bigger bang with this option.

Christine Bechtel – National Partnership for Women & Families – VP
That's the implementation timeline issue. I think we're really ... these. I mean, I get what we want to do and we almost should have started from the bottom of this list up, Paul, given the sentiment of the policy because I think everybody's going to say plus, plus, plus, plus on the development and implementation. But if you're talking about the pace of the program and you delay the program I just don't see how there's anything but a delay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

This almost might be an overall … because in some sense it's saying, the overall program there will be more people moving faster with this, so I might even return to this as a comprehensive attribute. It just does—either you can look at it as … things or as being an overall rating. Let me ask if the current sentiment is plus, plus zero, does that feel about right? Then we can come back and adjust if people agree it's an overall rating.

Christine Bechtel – National Partnership for Women & Families – VP
Obviously, I don't agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So let me try to come back here because I think it does capture the overall nature. So the next one is vendor development time for new functionalities: option one, keep the same, two is 90 day reporting and three is delay that one cell. Comments?

Christine Bechtel – National Partnership for Women & Families – VP
Paul, can I just go back to the last thing and I'll say one thing and then that'll be the end of it. I'm worried because we don't know what all of the impact feeds are for a one-year delay in terms of maintaining the pace of the program. I understand the hypothesis that more people might attest the year because they think that it's easier to meet next year. But on the other hand, you start to then bring ICD-10 implementation closer and all those other things, so I think it's just—my evaluation score is really based on what we can absolutely know, which is you delay the pace of the programs but we're hypothesizing about the ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Which is why I think once we go through everything else, we'll have a better sense. Can we comment on the vendor development timeline, the impact of option one, two and three. Anybody want to start out?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
In option one, it's two negatives because we can't make it if there's net new functions that's added. So again, this comes back to that balance. If it's just increasing thresholds with current certified software, you could do that, but that's not the current state even of what was defined.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Two negative.

M
I think the way you have it currently ranked is probably correct.

Michael Barr – American College of Physicians – Vice President, PA&I
Ditto.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay so you may not—

Christine Bechtel – National Partnership for Women & Families – VP
... we don't totally know the answer to that because I might say that it's one minus only because we haven't done the detail analysis like I said it's in three categories of figuring out how much of the criteria are truly impacted by the development timeline. There might be only three that are brand new and have to require coding and certification versus just certification.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay but I heard a sentiment for as listed as a placeholder. Remember these are not the final words, just the way that it opens discussion. Next line is provider implementation timelines. The way it's listed in the draft is two minus, zero and two plus.

Michael Barr – American College of Physicians – Vice President, PA&I
I would agree with your characterization Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Others?

Christine Bechtel – National Partnership for Women & Families – VP
Yes. I think that's probably right.

M
Yes. I'm okay with that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Next one is the whole concept of getting caught into the annual upgrade. This had to do with ICD-10—well okay let me take that out it. It's really when you change certification. Now that also might be based on a former perception. You can tell me whether—it's clearly a real thing. When providers have to upgrade, it's a big effort. What's the sense right now, the draft portion is minus one, minus one, zero.

Neil Calman – Institute for Family Health – President & Cofounder
I'm not sure that this fits in here because the vendors do their upgrades in all different kinds of timelines and in all different ways. I don't think we could say annual upgrade or whatever. This one doesn't quite make sense to me.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I agree. So we can table it for a moment and then maybe I'll delete it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Is this the ICD-10.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No. this is the one before that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay. I'm sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So now it's go to ICD-10. So we all know that that must be in place in the … or you stop getting your money, that's a head turner by October 1, 2013. Clearly, people are not going to go in September. So but 2013, people will be preoccupied, and there will be an upgrade involved. So you would want to piggyback that in some way. So do the options help give people the flexibility to tie their upgrade plans with ICD-10. The draft says minus one, minus one, plus one.

Neil Calman – Institute for Family Health – President & Cofounder
I have a question about this. I'm not clear. I've never been through an ICD upgrade on an EHR. So is there like an overlap period where the functionality would actually go in like a year before the deadline and people would accept codes in either ICD-9 or ICD-10. I guess what I'm asking is—you wouldn't put the upgrade in the day that you start using ICD-10. Obviously, people have to be trained and I just don't know how this stuff works. Do you know how it works?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Charlene, do you have a comment?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Again, I can't ... but I think the second scenario that you painted, which is that the upgrade is applied, we have to coexist with ICD-9 an ICD-10 for a period of time and there's a cutover actually the end of October 1st or whenever that is 2013. But we would have to have—I think it would at least give vendors and providers the benefit of coordinating those upgrades because you're going to also be upgrading the software to have the meaningful use software in that time frame. I don't know—everyone has their different time tables when they're going to be delivering them, but at least then you get the option of being able to do that and deliver it in one upgrade.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So just one answer your question is, yes you would, most people would upgrade and have this ability to code either way, and then you flip the switch and it all becomes ICD-10.

Christine Bechtel – National Partnership for Women & Families – VP
I have another question. I'm not sure this is the right question, but for people who have a practice management system that has to be upgraded to extent that it's not totally integrated as part of the EHR, does it complicate their work flow and their life because they're having—the upgrade comes as part of your EHR but you have to do a bunch of different work around the … system, which—well that's my question.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. It's true. It is complicated. Both have to be in place because the assignment is done in the EHR. It passes over to the billing system. I think if they're different, it's more complicated.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. So I think in my view, there's one argument that might … and again, I don't know the answer to this, but the closer you get to the ICD-10 upgrade, the more complicated and harder it gets for implementation because you have the other factor of the PM system that you need to do at the same time. So the delay might not actually be good here in that respect, I'm not sure.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I can give some more input on that. I could definitely ask the community and see because different vendors are approaching the ... certainly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What's the concept in this particular row is to say more flexibility is better. That's what this rating is basically saying. But I think if Charlene gets more of a sense of the vendor community for how they're planning to roll this out, that can certainly inform this row. Okay let's move on to—that's too bad ... not here—the operational complexity for the administrators, CMS and state and administrating these different options. Again, option one is the status quo. The option two is the 90 day reporting and three is the shift just to that one cell. Currently the draft is written as zero, minus one and zero.

Christine Bechtel – National Partnership for Women & Families – VP
I have would say zero on keep the same. I understand—I'm not sure how just changing the reporting period is a minus. So I would almost suggest no impact because what they've already done in stage one, I would have thought, but again, the folks that CMS ... that the delay of one year would actually be more complicated than option one or two.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So Josh do you have a sense, or maybe Jim do you have a sense of this line? Would one of these be more challenging? Clearly I think the ....

Josh Seidman – ONC
I think keeping things the same as currently the expectation is in one sense is the easiest than that keeps things on track. I think that having different reporting periods does create some complexity. It certainly creates complexity in terms of thinking through the implications on the clinical quality measures, which is

... but we would then need to go through analysis of which of the critical quality measures could we actually expect to have useful data for the purposes of the delivery system reform program and things like that. So it creates at least a certain amount of complexity in that sense.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well I think you're thinking a little bit like the draft shows, which is sort of a neutral minus one neutral. Is that a reasonable formulation?

Christine Bechtel – National Partnership for Women & Families – VP
Let me ask a question at least with respect to option three. The delay of one year, does that assume that the reporting period for ... which is how it's written in the reg?

M
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. I think this is a fair representation based on what Josh said. There's a little complication with changing it to 90 days, probably a lot having to do with the quality measures. The next line is the quality measurement and reporting. It has the same—and maybe we want to combine these—it's the same neutral, minus one, neutral on the draft.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. I think that makes sense.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Should we just combine it though with the one above, which is the operational complexity? I think based on what Josh said, it's almost identical.

Neil Calman – Institute for Family Health – President & Cofounder
This is one where, again, I think we would need to do the analysis. I think depending on measures, they could create some pretty big challenges like ACO measurement thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I would agree with it. So in addition to the operational complexity, it really, you're only getting to see people in three months period of time, that throws you for a loop there. I agree a second attribute; it may have the same kind of a rating system as the second attribute.

Okay the next one is what Neil introduced, which is you may have all these aspirational goals but if it's not going to fly because of all the other realities that CMS has to deal with it, it's not very helpful. So this is a probability of our recommendations the standing at CMS. People want to comment on that? Neil, you want to say anything?

Neil Calman – Institute for Family Health – President & Cofounder
Paul, yes, I think that in relationship to option three, I would give it a two plus, and probably in relationship to option two a one plus and in relationship to option one, probably a one minus.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay so that's the first offer. Comments on his proposal?

Christine Bechtel – National Partnership for Women & Families – VP
Neil, can you explain the criteria again.

Neil Calman – Institute for Family Health – President & Cofounder

Yes. Basically the probability that the recommendations that come out of the Policy Committee would be adopted in the final rule. Basically I think that we're less likely to get negative feedback and have it affect the approval of our recommendations at the end but if we go with option three, a little less likely if we go with option two and probably more likely to get that kind of pushback if we go with option one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that feels right to me.

Christine Bechtel – National Partnership for Women & Families – VP
I agree with the assessment on option one. What did you have for option three, Neil?

Neil Calman – Institute for Family Health – President & Cofounder
Two plus. I think we're much less likely to get negative feedback and to get our recommendations through if we go with option three, which basically gives the people who qualified in 2011 an extra year to adopt this and gives the vendors that time to establish their certification of the requirements that we call out.

Christine Bechtel – National Partnership for Women & Families – VP
Well I think that's right for the debate today but I would not underestimate the pushback that people will find later. I also think—my ranking on this would be dependent on whether we do it, and I think we should go back and say if part of the option is delaying stage two by one year, if stage two should drive more value than I think the amount of value that we were originally hoping for stage two, given that there is an extra year of time. So for example exchange capabilities will evolve and it actually has a little more ... ,if that's the case, which is something I would highly support doing over the next month or so in that context. But that may create additional pushback later, but I agree with you that right now it does help.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So let me—I agree with what Neil said. I wonder if we could now return to—and I agree with what Christine just said. I think this gives us a fresh approach and literally not only by this last attribute says I think people are going to welcome this change. It makes sense and it sort of gets us out of essentially what was a bind for 2013 for that group. And yet, gives us the opportunity to perhaps push a little harder on making sure that the things that we want in the stage two, the care coordination things, strengthen that a bit.

With that in mind, can I return to the second line, which I think is a nice way of stating what the overall thought is. Which is what we want to do is maintain the pace of meaningful use electronic health record systems up the escalator to support all the programs that we need it for. As a sort of overall rating of these different options, what do we think? If you look at the table—now let's see, maybe what I could do is, Judy, if I sent you the table right now that I have in front of me, would you be able to turn around and post it?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. I can do that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So let me do that so that you can see where we have ended up so far.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, can you summarize, like just give us some counts for the three options?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Hang on, let me just get this off so that it can start going.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
In the meantime, I did want to comment and just kind of add on to what Christine said. I think that again, having time for the hardest things providers are having challenges with are getting the external public

health reporting, the HIE infrastructure, Direct, this does two things. It gets more people in the elevator sooner, but in addition those other pieces, it gives them some time to mature. So I do think we're in a better position. I think it will help.

Christine Bechtel – National Partnership for Women & Families – VP
So would you agree Charlene, then that you as part of our communicating these options and our analysis of the ONC that we would go back and looking at option three say if you delay one year then our recommendations for criteria might change in the area of HIE and quality measures, I agree with you there. Then, I would probably add to that list care plan as well, that we might say these are the additions, these are the criteria that we would suggest if the program has an extra year to mature.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We actually have a recommendation on care plans. Again, I think care plan is just a challenge because if you recall on our testimony, we heard that it's not current practice so there's just a lot of concern about care plan, but if we could maybe have a more generic approach or something that may be possible. I definitely agree that we need to relook at the criteria in light of the change.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Judy, do you have it yet?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. I'm getting ready to send it out.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great thank you. Okay so let me start reading it for the folks who may not have access right now. Support of the health reform, it is two plus, one plus, zero. Vendor development timeline for new functionality is minus two, minus one, two plus. Provider implementation timeline is minus two, zero, two plus. ICD Synergy is minus one, minus one, one plus. CMS operational complexity is neutral, minus one, neutral. CQM measurement and reporting is neutral, minus one, neutral. Probability of recommendation standing in the final rule would be minus one, plus one, plus two. I apologize, I did not delete the need to perform annual update when I sent out that ... Web. The other thing is the maintaining MU—oh, that's interesting. You haven't put it up yet, have you?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. I haven't seen it yet.

Judy Sparrow – Office of the National Coordinator – Executive Director
No. Katelyn, can you put that up? I sent that to you.

Katelyn
Yes. I'm just remediating that right now.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. I think the other question is probably vague, Paul, is whether these categories are equally weighted.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Right now, we're not being so quantitative. I think we'll have to take that into account if we need to.

Christine Bechtel – National Partnership for Women & Families – VP
Well and I think in our options and the way we present the options, I think that the first three are probably the most important, and I think there's probably agreement in the first three are really important to consider.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Katelyn, are you able to just delete that need for providers to provide annual upgrades line?

Katelyn
I'm afraid this is a PDF only.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay fine. Okay so for those just please ignore that particular line. So you see in front of you how it's shaping up, and my guess is you look down the columns in option one, two and three, three actually has the least zero negatives and the most positives. It looks like option two has more negatives than option one. So it's almost in ordinal, it might be option three, then option one, then option two.

Christine Bechtel – National Partnership for Women & Families – VP
Paul I think actually by my count, you've got four negatives in option three and you have six in option one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was looking at rows and you're counting .... That's fair. So option one is worse?

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay so ordinally, it goes right to left, option three, option two, option one.

Christine Bechtel – National Partnership for Women & Families – VP
Right, option one and two have the same amount of positives but for option one ... two more negatives.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I'm wondering if that would mean it would be something like it's almost two plus for option three, a zero for option two and a minus one, let's say, for option one. So that'd be two plus, zero and minus one reading from right to left. How do people feel about that?

Christine Bechtel – National Partnership for Women & Families – VP
I'm not sure what you're—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay so in the overall, which was learning to maintaining the meaningful use pace up the escalator, I would summarize these as minus one, zero, plus two.

Christine Bechtel – National Partnership for Women & Families – VP
I guess I'm just not sure at this point that it matters. Right? I think we're—it's so clear that everybody is thinking of there are the most positive attributes about option three and the least about option one. I'm not sure it's like worth our time even spending— We get the point, now what we need to do is I think there … two things, one is this describe narratively why we thought what we did and in a balanced way, talk about the relative more important of the first three criteria. Present the options and then go back and I think this is what we need to do fairly quickly and say okay since option three had the most positive attributes, here's how you could get more bang for your buck given that people would have an extra year to do it, doing that revision of the criteria to reflect the additional time that people would now have in the evolution in the market place.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's what I proposed—because it is so clear, that's what I've proposed discussing tomorrow, is how we went through this and what was part of our revelation in terms of how the certification program interacts with the meaningful use objectives and that localized problems, that localized cell. Then talk about this is the way we're heading in terms of part of this package, the timing part of this package. Then mixed with the feedback we get tomorrow from the policy committee, we'll go back re-review all of the stage two draft

recommendations and think about well with the benefit of time, how would that change some of our thoughts there. I'm just sort of parroting back what you said is my understanding.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I guess I would make a couple of amendments or whatever. One is, I would ask the committee are there other timing options that we haven't considered. The second is I would be hesitant to characterize this as the way we're heading because again we're trying to present options. Now if one is more clearly thought through or favorable then another, it's CMS's desire to choose and they should go through the criteria that we use and evaluate them on their own measures as well. But again, I'm really hesitant to be making a recommendation on an operational issue rather than presenting some options. Then, the third thing I would say is, I'm not sure that it is a good use of time to try to revise with the whole committee on the fly what more we could do in stage two. I mean we could say—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well let me interrupt there. Now I wasn't planning for the committee to weigh in. That's something we would take back as a homework.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. I agree with that. We might invite them to flag issues where they don't think we've gone far enough in the abstract, and then let us work through with different timing options, what could that look like, but I'm glad you clarified that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, how are people feeling about where we're ending up with our sense of looking at these various options?

M
Well I like it. I think it's a very coherent presentation to the whole committee. I would just echo Christine's statement that I think it's really important that we explain how we got here and that the expectation of let's pushback because of the increased time is still deemed to our recommendation. That ... to say that very clearly so that people realize that there is a tradeoff in that recommendation.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. I think we have to be clear that we are also intending to advance some criteria further given the needs of health reform and the additional year that what we're presenting is not just the way a year as what the option of having them close to the top. It is if this is an option, we're going to get more value for what we're asking for given that option.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Alright, I think this has been really a revelation in this ... advancement, really. Okay, good. Now I realize that people didn't get the PowerPoint until late. I just sort of open it up for any other tweaks to what we're going to present again. It's still a draft at this point. We're soliciting full committee feedback on some of the work we've done over the past month, six weeks.

M
I just haven't had time to go through it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right I understand that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, the one comment I know that you'd asked us to a little homework on was that demographics piece .... I've got the report on that. Again, the vendors are just going to look at that, because we didn't really do the homework but it appears that in the Institute of Medicine report, it's the recommendation to establish a standard, not the standard itself. Again this doesn't preclude us from putting it in with, depending on the timing discussion, but the standard does need to be defined. So that's a big step, so

we can't do that today because we don't have the standard. I can send you the reference if you want on that one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Super. I'll just put a couple words in here to indicate that will certainly … that. Thank you.

Well I want to thank this group for the many, many hours we've spent on the phone, in person, short notice and all the time and effort and just the thought you put into this. I think we were coming up with a good set of draft recommendations to put in front of the committee for more feedback. But also, I think we've gotten to a better place where we can sort of give the flexibility and timing that is needed by the industry and the providers and at the same time advance this agenda as was encapsulated in the spirit of HITECH and it supported health reform. So I think we really are coming closer to a good compromise that's workable and that's ... for good I think.

Any other final comments before we open it up to the public?

Judy Sparrow – Office of the National Coordinator – Executive Director
I guess a reminder that Friday's our specialist hearing here in Washington at the Washington Hilton, and the next call is May 20th of this group.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I cannot participate on that. I think Judy is also off that call, so I don't know if we can reconsider another time, and it wasn't on our calendar.

Neil Calman – Institute for Family Health – President & Cofounder
Yes, I can't make that either. I have a board meeting that exact time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay well, I'll look for another date and time and talk with George and Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, that sounds good.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay, are we ready for public comment?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. Please.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you check and see if anybody wishes to make a comment.

Operator
We have one comment from Eric Durbin.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you Eric. Go ahead.

Eric Durbin – Kentucky Cancer Registry
Hi. This is Eric Durbin, I'm with the Kentucky Cancer Registry, and I have a couple comments with regard to cancer registry reporting as a stage two menu option. Would like to point out that cancer is actually the only chronic disease with a well-established surveillance infrastructure so the reality is that all 50 states, cancer is reportable, and all 50 states have a well-established health cancer registry. In our experience, we're currently working on a project to try to hook up direct reporting from EHRs to our cancer registry here in Kentucky. In our experience, our physicians and providers are very interested and wish to report to us through their EHRs but they also of course want to meet the meaningful use objectives and those to

tend to trump their other desires. So if cancer registry reporting isn't explicitly mentioned, we're finding that vendors aren't actually implementing that capability in their products.

Finally, I would just like to remind the committee that cancer remains the second leading cause of death in the US, and of course is a large proportion of our health care costs. So our concern is that if cancer registry reporting isn't explicitly mentioned then perhaps your escalator or your elevator may be one of its most important passengers, so just again to advocate for explicit mentioning of cancer registry reporting as a menu option for meaningful use.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you Eric. Any other public comment?

Operator
Yes we have another comment from Flora .... Please proceed with your comment.

W
Hi, good morning. My name is Flora and we just a quick verification ….

Judy Sparrow – Office of the National Coordinator – Executive Director
… tell us where you're from, Flora, which organization?

Flora
From Texas DHR.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay go ahead.

Flora
Okay thank you. Regarding the public reporting, in our state syndrome surveillance, our state is not ready to adopt immunizations. Also they're not ready to adopt HL-7. It's only reportable labs they are ready to adopt HL-7 messages. Our question is can we still choose immunizations to submit and fail for stage one. Is that acceptable or do we have to use ...?

Judy Sparrow – Office of the National Coordinator – Executive Director
Is anyone going to comment back to Flora?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Are you saying that your state is incapable of receiving HL-7 messages for immunizations and labs and you'd like to know which one to use.

Flora
They're incapable of adopting syndrome surveillance and immunizations. They're only capable for labs.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well unless you're going to get an official answer from CMS, I'm not sure if that's our role here.

Art Davidson – Public Health Informatics at Denver Public Health – Director
No, I wasn't. I was just trying to understand the question.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you Flora. We will accept your comment. Anybody else on the line?

Operator
No there are no more comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay. Thank you. Thank you Paul and everybody.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great. Thank you Judy, and thanks everybody and see you tomorrow.